Guide to Chapter 9

CHAPTER 9

Creating Comprehensive Cost-Effective Systems: System Design Issues[1]

Making home and community services readily available to and accessible by individuals with long-term care needs requires that states design comprehensive, cost-effective delivery systems. Design dimensions that need to be addressed include establishing meaningful access to home and community services, managing dollars, and making sure that Medicaid home and community service delivery is coordinated with other community service programs. Federal Medicaid law and policy give states considerable latitude in designing and implementing such systems.

Introduction

Too often, persons in need of home and community services lack them, not because services are literally unavailable, but because the service system makes the process of gaining access to them cumbersome, confusing, and even unfriendly to consumers. Indeed, individuals and their families can find the process so difficult or upsetting that they simply give up and go on struggling without the services they need.

States can largely eliminate these difficulties if they design home and community services systems that have five major components:

- An outreach, application, and enrollment process that is truly accessible to people with disabilities (and their families)
- A structure that connects individuals with the services they need
- Effective management of dollars in ways that promote economical delivery of home and community services, thereby making such services available to the maximum number of people
- Payment and contracting mechanisms that encourage provider participation
- Coordination among and across programs, so that duplication is avoided at the same time that individuals with disabilities are ensured access to vital supports that address home and community service needs—outside as well as within the scope of the Medicaid program.

Each is discussed in the sections that follow. The whole system design task needs to be approached in the context of state laws and policy goals, historical factors, and the unique needs of a variety of target populations. Federal Medicaid law and regulations must also be taken into account. But as the follow-

ing discussion makes clear, these allow states considerable latitude in working out a system design that best fits their circumstances and program management objectives.

Outreach, Application, and Enrollment

The outreach, application, and enrollment process is the component of the home and community service system that is charged with (a) making all potentially eligible individuals aware of the availability of services, and (b) ensuring that those who are eligible for services are enrolled in the Medicaid program. All these steps must be completed as rapidly as possible, since a consumer's need for services may be critical.

The next three subsections describe a variety of actions states may take in implementing effective outreach, application, and enrollment system components. Some of the activities described may be paid as Medicaid administrative expenses. To qualify under this cost category, activities must be determined necessary for the proper and efficient administration of the state's Medicaid program.[2] It is important to note that Medicaid reimbursement is not limited to activities conducted by Medicaid agency staff. Reimbursable activities may also be conducted by other agencies, organizations, and individuals through contractual or cooperative agreements with the Medicaid agency.

Outreach

Outreach covers the set of activities the state undertakes to identify and inform potential applicants about the availability of home and community services and to provide information about how and where consumers can get them. There are many different ways to disseminate information concerning home and community services. Effective outreach programs incorporate several strategies to reach consumers on their own terms.

Activities can include collaborating in outreach with the "generic" human services networks individuals are likely to access or contact when they seek services (e.g., Area Agencies on Aging, seniors programs, Independent Living Centers, community developmental disabilities agencies, mental health centers, public health agencies that provide Maternal and Child Health Services, and homeless shelters). For example, a state may provide periodic, repeat orientation training for a network's intake staff to make sure they are well acquainted with what home and community services are available. In addition, states can reach out to other community networks (e.g., faith-based organizations) to which individuals might turn for assistance and guidance. These activities may be reimbursable under Medicaid when all Federal requirements are met.

State personnel might also attend conferences and meetings of consumer organizations, to make presentations concerning available services and to field questions from individuals interested in knowing more details about them. In addition, state personnel can work with such organizations to prepare newsletter articles concerning home and community services. Yet another potentially useful tool is preparing and distributing videos. The important point about these activities is, not only to provide basic information about available home and community services, but also to put a more human face on the information by including stories of and by persons who have benefited from them.

Addressing cultural diversity is particularly important. States may do this by making information available in relevant languages and/or contracting with individuals and community organizations to conduct outreach activities in a culturally appropriate and sensitive fashion. Similarly, states need to ensure that individuals with communication, cognitive, or sensory impairments can have access to such information.

The advent of the Internet provides exciting new opportunities to make information concerning home and community services more accessible to individuals and families. However, these opportunities may not be realized unless state agency and Medicaid program websites are designed with the information needs of consumers seeking services in mind. Additionally, they need to be accessible and usable by individuals with a wide range of physical, sensory, and cognitive disabili-

ties. States can become familiar with Federal guidelines for website access by going to www.access-board.gov. When designing or redesigning their sites to address such needs, states may want to consider teaming up with consumer organizations to launch sites that are distinctly consumer-oriented and consumer-friendly.

Application

Application is the next step in the process of gaining access to home and community services. The crucial point here is to ensure that the application process is, in fact, accessible to persons with severe physical and/or cognitive limitations.

Some consumers may be reluctant to apply for Medicaid for a number of reasons. A "welfare stigma" still attaches to the Medicaid program and some people may be anxious about the application process because it represents a "failure"—the inability to provide for themselves or their children. Others may be concerned about revealing personal financial information to "strangers." Still others may find the paperwork requirements to prove financial eligibility difficult to meet.

Overcoming these problems can be done in several ways. States should (a) encourage potential applicants to enlist trusted allies (e.g., family members and friends) to assist them in the application process, and (b) have sufficient staff so that the necessary time can be spent with applicants to ensure the process is understood and satisfactorily completed. In addition, the application forms themselves, along with associated materials, must be clear and easy to understand. To this end, such materials should be pretested and revised until they are readily understood by consumers. Another potentially useful strategy is employing people with disabilities (e.g., self advocates) to provide assistance and information to help applicants through the process.

States may also provide special training in disability issues and concerns to intake workers. In addition to being knowledgeable about home and community services generally, intake workers must be well-versed in any special provisions or rules that affect eligibility for people with disabilities. The importance of such training is highlighted by the fact that in some states which have adopted particular eligibility options (e.g., the TEFRA 134 option for children with severe disabilities), staff at intake/eligibility levels have not been made aware that the options are available.

States also might consider conducting customer satisfaction/feedback surveys. This is a good way to obtain first-hand information about how consumers feel about the Medicaid application process. Alternatively, individuals who have been through the process recently might be convened in focus groups, to discuss their experiences and provide ideas for making the process more consumer-sensitive and -friendly.

Yet another step is using outstationed or mobile workers to take applications and answer questions at locations around the community (including the consumer's own home), where individuals might be more comfortable than in an agency office. Advances in computing make it possible for workers to take applications almost anywhere. Using mobile workers can be especially important in rural areas and for reaching people who do not have transportation. To facilitate the application process, outstationed workers may be located at hospitals, nursing homes, or rehabilitation facilities to link with discharge planning teams. States may also contract with other human service networks to perform initial intake activities for the consumers they serve (e.g., Independent Living Centers or Area Agencies on Aging), so long as decisions concerning enrollment are made by the entity designated by the state to make the final eligibility determination. Additionally, states may find it useful to identify the points in the application process at which the current system facilitates institutional placement or establishes the institutional option as the norm, and to target educational efforts about home and community services at those points.

Finally, states can take steps to improve access to home and community services by individuals with disabilities who have limited English proficiency. Federal policy (Title VI of the Civil Rights Act of 1964) prohibits discrimination based on national origin. Entities that receive Federal Medicaid funds (including public agencies and

service providers) must take affirmative steps to accommodate the needs of individuals with limited English proficiency, whether in accessing Medicaid services or during provision of such services. FFP is available for state expenditures related to the provision of oral and written translation administrative activities and services provided for CHIP or Medicaid beneficiaries. It is also available for such activities or services, whether provided by staff interpreters, contract interpreters, or through a telephone service.[3] Similarly, FFP is available for providing interpreter services as an accommodation for hearing-impaired individuals as required by the ADA, to the extent that they are not otherwise available without charge.

Enrollment

After individuals apply for home and community services, they can only start receiving such services after the state determines they meet financial eligibility criteria (if they are not already eligible for Medicaid services) along with a state's health/functional criteria (consistent with Federal guidelines), and after a service plan has been drawn up and approved. In order to begin services as quickly as possible and thereby avoid hardship for the beneficiary, it is important that these activities be completed as expeditiously as possible. Some of the steps that states take to expedite the process include preparing service plans at the same time that level of care determinations are being made, or preparing provisional service plans to start some services immediately until a full service plan can be worked up. In other cases, states have eliminated requirements they deem unnecessary (e.g., dropping a requirement that the physician approve the service plan).

In sum, creating an effective home and community services program requires a commitment to changing the environment for delivery of long-term services—including conducting outreach and other education activities that inform individuals and service providers about the types of services available and making all parties aware of the full range of opportunities available to them. It is important that outreach, application, and enrollment processes be geared to making information about these opportunities widely available wherever and whenever decisions are being made about long-term services (e.g., as a part of discharge planning from institutional settings or when individuals first seek long-term services).

Connecting Individuals with the Services They Need

Designated case managers or service coordinators are responsible for conducting or coordinating the activities involved in connecting individuals with disabilities to home and community services. Under regular state Medicaid plan benefits (e.g., the personal care state option), there is no Federal requirement that service beneficiaries have a designated case manager, but many states provide one nonetheless.

This section discusses the program design options available to states for providing case management services to persons eligible to receive home and community services. The design of case management systems varies dramatically from state to state and program to program. Case managers or service coordinators may be public employees, work for private organizations, or be independent contractors. In some systems, case managers are responsible for all elements of service planning/authorization. Elsewhere, service coordinators prepare service plans that must be approved by the administering public agency. Typically case managers have additional responsibilities as well, including monitoring service provision, providing ongoing assistance to the individual in addressing problems in community living, and addressing emergency/crisis situations. (See Chapter 5 for a detailed discussion of case management financing alternatives for states.)

States follow one of two principal organizational models in addressing this aspect of system operation: (a) organizing around specific target population groups, or (b) using a single structure to encompass all target groups.

Organizing around Target Population Groups

Organizing home and community service delivery systems around specific target population groups

Organizing around Target Populations: Two State Examples

Aging Services in Indiana

Indiana organizes delivery of home and community services around the network of Area Agencies on Aging (AAAs). The AAAs administer programs funded under the Federal Older Americans Act (OAA). With the launch of Indiana's CHOICES HCBS waiver program, the AAAs were also designated to perform preadmission screening for Medicaid long-term care services, so that delivery of these services could be integrated with OAA and other locally available services for seniors.

Developmental Disabilities Services in Kansas

In Kansas, services for people with developmental disabilities are organized around 28 local, nonprofit Community Developmental Disabilities Organizations (CDDOs). Kansas law specifies that these organizations are the single point of entry for developmental disabilities services. The CDDO provides or arranges for service coordination for people who have a developmental disability, develops local strategic plans to improve service delivery and availability in the region served by the CDDO, manages local provider networks, and integrates local and state funding of developmental disabilities services. By law, the majority of the governing board of each CDDO must be individuals with developmental disabilities or members of families that include someone with a developmental disability. The CDDO also serves as the local point of entry for Kansas's HCBS waiver program for people with developmental disabilities.

(e.g., people with mental illness, elderly persons, people with mental retardation and other developmental disabilities, and so forth) is the more typical state pattern. Many states, for example, have state laws that establish organizational structures for the delivery of services to specific target populations. These state "governing laws" are especially common with respect to services for people with developmental disabilities and people with mental illness. In such cases, states usually seek to integrate delivery of Medicaid home and community services into these more established structures. This enables states to use preexisting, established points of entry, and facilitates development of a "seamless" service delivery structure.

When services are organized along target population lines, a state administering agency is typically charged with overseeing delivery of services to the specific target population, including operation of the point of entry system. In some cases, the state administering agency operates the points of entry system directly through regional offices, as permitted by Federal policy. With respect to HCBS waiver programs, for example, there is provision for state Medicaid agencies to enter into administrative agreements with other state agencies to conduct and manage various aspects of the operation of these programs. Such agreements help avoid the emergence of bifurcated administrative structures and permit the state Medicaid agency to take advantage of the expertise of other state administering agencies.

Using a Single Structure to Encompass All Target Groups

In this model, a local entity serves as the single point of entry for individuals with disabilities of all types. Sometimes called the one-stop shopping model, this organizational structure establishes one place to go for individuals and families wishing to gain access to long-term care services of many types, including home and community services. These single point of entry systems themselves may have specialty branches or linkages to specialty provider networks. This type of model is less common for home and community services than the model organized along target population lines.

Pros and Cons of the Two Models

Pros and cons are associated with each model and there are exemplary systems organized along both lines. Advantages cited in support of organizing

Minnesota's Single Point of Entry System

The state of Minnesota provides several home and community benefits (e.g., personal assistance) that cut across target population lines, along with specialized services keyed to the needs of particular target populations. In Minnesota, delivery of human services is organized around county human service agencies. These agencies are designated the single point of entry to all types of services—including public assistance, social services, health, and long-term services. Thus, anyone in Minnesota who needs publicly funded services can gain access to them through the county human service agency. This structure enables the individual (or family) to access the full range of services and supports Minnesota makes available, including home and community services. With respect to long-term services, counties manage intake, assessment, preadmission screening, and service authorization.

Minnesota's system is especially well positioned to tie together state and local programs. In its larger counties, specialty branches are also commonly found within the human services agency to meet the needs of specific target populations (e.g., people with developmental disabilities). One reason why Minnesota is organized in this fashion is that counties themselves are required to provide a portion of the funding for various services. In addition, many Minnesota counties provide a significant amount of local tax dollars, over and above required state matching requirements, to underwrite human services.

service systems along target population lines include: (a) it ensures that the specific needs of each target group are addressed in an expert, focused, and unified fashion; (b) it provides for the coordination of multiple Federal, state, local, private, and third-party funding streams that are especially relevant to meeting the needs of the target population; (c) it facilitates optimal use of the service delivery systems associated with different target populations, some of which are very large and complex in their own right and, thus, require dedicated management and oversight; and (d) it fits well with long-standing service systems. Disadvantages often cited with respect to organizing systems along target population lines include: (a) duplication of administrative structures; (b) overspecialization of services; (c) difficulties in coordinating the delivery of specialized services with services and benefits applicable to a wide range of target populations; and (d) difficulties in having their specific needs met for populations that do not have a designated service delivery agency in their state.

Advantages cited in support of the single structure model include: (a) it avoids individuals and families having to figure out which of many systems might best meet their needs; (b) individuals with disabilities have many needs that cross disability category lines and can be best addressed through a unified service system; (c) individuals and families can be afforded better access to a wider range of services than are available within more narrowly defined specialized systems organized around particular target populations; and (d) integrated systems are more economical to operate from an administrative cost standpoint, because they avoid duplicative organizational structures. Frequently cited disadvantages of such systems include: (a) they can be especially complex to administer; and (b) the specialized needs of specific target populations may be neglected.

Federal policy leaves it to each state to determine how best to organize its home and community service delivery system(s), as evidenced by the disparate organizational structures presently in place. The main Federal policy requirements in this arena are two: a state must administer its program uniformly across the state (unless a waiver of statewideness has been approved); and Medicaid services must fall under the authority of a single state agency that is responsible for ensuring the Medicaid state plan is being followed.

Federal policy does dictate that HCBS waiver programs be structured along target population lines. However, this policy does not dictate that a state establish a distinct, separate point of entry service delivery system for each HCBS waiver program. Nor does it prevent a state from designing HCBS waiver programs that define and offer benefits

Waiver Program Structures: Two State Examples

New Hampshire

New Hampshire has two distinct HCBS waiver programs: one for people with developmental disabilities and one for individuals with acquired brain injuries. Both of these programs are operated through the state's developmental services systems, using the state's long-standing network of developmental services area agencies as points of entry. While there are some differences in the needs of each target population, tying the HCBS waiver program for people with acquired brain disorder into the developmental services system enables individuals to gain access to an established provider network and avoids the expense associated with having to establish new points of entry for a relatively small HCBS waiver program.

Utah

Utah operates three HCBS waiver programs serving, respectively, (a) people with developmental disabilities; (b) individuals who have a physical disability but who are not developmentally disabled; and (c) individuals who have had a traumatic brain injury. All three are operated through the Division of Services for People with Disabilities (DSPD) service delivery system, and all employ the same point of entry—DSPD's regional offices.

that cut across a variety of target populations.

Whichever organizational model a state chooses, the following common system design considerations need to be taken into account, to ensure access by and responsiveness to individuals with long-term service needs and their families:

- *Local entry offices must be available in all parts of a state,* including rural areas. This may entail the use of multiple entry mechanisms. For example, in Montana (a very large and very rural state), case management services for home and community services for people with developmental disabilities are furnished by a combination of state regional office personnel and private contractors. The private contractors furnish service coordination in areas of the state that are too far away from the regional offices or too sparsely populated to justify the expense of setting up a state regional office.

- *There must be adequate resources to underwrite case management/service coordination activities.* Delivery of home and community services very often involves coordination across multiple public and private programs, as well as with informal caregiving networks, and intensive collaboration with individuals and families. Without adequate resources for service coordination, bottlenecks inevitably slow the provision of services and supports as well as undermine ongoing monitoring of service delivery.

  The amount of service coordination resources needed to ensure that service delivery systems are responsive to individuals and families depends on several factors—including family involvement, the degree to which the individuals desire and are able to serve as their own case managers, and the extent to which the individuals' disabilities may place them at risk. In developmental disabilities services, for example, many states seek to maintain case manager to consumer ratios between 1:30 and 1:45 in the case of adults; but higher workload ratios are common in the case of children with involved families.

- *Case management/service coordination must be conflict free.* This will help ensure that individuals and families are made aware of all service options, that they can exercise free choice of provider(s), and that there is a third party to whom consumers can turn if service problems are encountered. There should also be safeguards to ensure that service coordination is operating in the best interests of consumers. For this purpose, several state HCBS waiver programs are structured so that certain key aspects of service coordination may not be provided by any agencies or individuals also paid to furnish direct services to the individual.

- *System activities should be conducted in a culturally and disability-competent fashion.* This includes translating materials into different languages / media and providing interpreters (linguistic or sign-language services, for example) as necessary to accommodate the needs of the individual or the family.

As this discussion implies, operating an accessible and responsive point of entry network can be costly. Federal law and policy provide various options to secure FFP in these expenses, with respect to both operation of the point of entry system and various other administrative expenses.

States may obtain FFP for this purpose in three major ways: through the targeted case management optional state plan service, through an HCBS waiver program, or through administrative claiming. (Chapter 5 provides a detailed discussion of the pros and cons of each of these approaches.)[4] For a structure organized around target groups, there may not be much difference between the three alternatives. For a single point of entry system, however, the targeted case management option is particularly advantageous for two reasons. First, targeted case management may be made available to all Medicaid-eligible individuals (including HCBS waiver participants) who need home and community services without regard to type of funding source. This coverage option can be very useful in establishing a broad-based service coordination / point of entry system. Second, in the case of individuals with a developmental disability or a mental illness, a state may limit the providers of targeted case management services to the case management authorities already established in state law. This enables states to tie delivery of targeted case management services for these populations into point of entry systems that are already established.

Managing Dollars: General Considerations

At both Federal and state levels, it is enormously important that services and supports underwritten with taxpayer dollars be delivered in a cost-effective and efficient manner. States have limited dollars. If services are extremely costly, policymakers may feel they have no choice but to restrict access to home and community services or not offer them at all.

Maximum cost-effectiveness is particularly crucial given the expected increase over time in the number of individuals seeking HCB waiver services. This anticipated steady increase stems principally from demographic factors, such as the aging of the nation's population. As a result of people with developmental disabilities enjoying increased longevity, the demand for developmental disabilities services is increasing at a rate higher than population growth alone. There are large numbers of such individuals who now live with aging family caregivers. As these caregivers become less and less able to support the family member with a developmental disability, there has been a marked increase in the demand for residential services, including services offered through HCBS waiver programs.[5]

In designing an HCBS waiver program, a state should take into account future demand for services. Some of this demand may be absorbed by turnover among individuals served in the program (due to loss of Medicaid eligibility, voluntary termination, an individual no longer requiring services, or death). Such turnover is often insufficient, however, to enable a state to serve all individuals who seek and are eligible for HCB waiver services. If future demand is not accounted for, a waiting list can result or individuals might have to seek more costly institutional services instead.

Spending for home and community services is affected by two factors: the number of individuals who receive such services, and the per capita costs associated with furnishing services to such individuals.[6] In this context, managing dollars often boils down to developing strategies that address the demand for home and community services while, at the same time, taking steps to ensure that per capita costs are no greater than strictly necessary to acquire the services and supports individuals need.

As home and community services have unfolded over the years, managing dollars has come to

revolve around two tests: budget neutrality and cost-effectiveness:

- The **budget neutrality test** involves comparing total spending for long-term care services with and without offering home and community services. In other words, it asks the question: If home and community services are offered, will there be an offsetting decline in spending for institutional services or will overall spending increase?

- The **cost-effectiveness test** involves comparing per recipient spending on furnishing institutional services to per recipient spending on furnishing home and community services to the same group of individuals. A home and community service program is said to be cost-effective if its per recipient expenditures are no greater than the per recipient expenditures in institutional settings.

Budget neutrality is complex to assess, because it depends on determining how people who need and would benefit from long-term care services and supports will react when home and community services become available. Most individuals strongly prefer to remain in their homes and communities, even though many have functional limitations just as severe as those of individuals who receive institutional services. Thus, when institutional services are the only long-term services offered, many individuals will not seek formal long-term services and supports at all unless they are impossible to avoid (e.g., when a person's condition deteriorates to the point where constant care is required or overwhelms the informal caregiving the person has available).

For this reason, the number of individuals who meet institutional admission criteria is far greater than the number who actually seek institutional services. When home and community services are offered, however, people who would not accept institutional services will come forward to obtain home and community services, because such services match up better with their desires. That is, the overall expressed demand for long-term services and supports is greater when home and community services are offered in addition to institutional services than when they are not.

The budgetary impact of this increase in expressed demand depends on whether offering home and community services will lead to a sufficient reduction in demand for institutional services (typically much more expensive to provide) that is large enough to underwrite the costs of making home and community services available. Only when one completely offsets the other is budget neutrality achieved. For more than two decades, researchers have been analyzing the effect of newly offered home and community services on demand. Not surprisingly, this research affirms that more people will seek services when states make available services and supports in the home and community. Further, this research seems to show that achieving budget neutrality hinges on employing one of two strategies.

The first is to impose very stringent eligibility tests for receipt of home and community services. These tests do narrow the demand for home and community services. But they also make ineligible many individuals with severe disabilities who could benefit from home and community services. The second strategy is to provide residential alternatives (e.g., assisted living) that divert demand away from institutional services. In home and community services programs for people with developmental disabilities, for example, most states offer a variety of residential alternatives. This reduces demand for ICF/MR (institutional) services, which are very costly (approximately $78,000 per individual for a full year's services in 1998). Due at least in part to the rapid expansion of HCBS waiver programs for people with developmental disabilities, overall utilization of ICF/MR services has been declining steadily since 1993.

It is, in fact, extremely difficult to achieve budget neutrality when offering or expanding home and community services as an alternative to institutional services. A state's ability to achieve budget neutrality is tied in large part to its historical willingness to tolerate numbers of people with unmet needs. As unmet need is reduced, the pressure on states to increase the total number of persons served (in all long-term service settings, both institutional and HCBS) is correspondingly lessened.[7] However, budget neutrality is but one of many policy objectives states pursue with respect to long-term services and supports. Other objec-

Demand for ICFs/MR in Kansas

In 1993, about 2800 individuals with developmental disabilities in Kansas were receiving either ICF/MR or HCBS waiver services. About 1800 were served in ICFs/MR (including 900 individuals in large state-operated facilities). By January 2000, about 6000 individuals were receiving either ICF/MR or HCBS waiver services. The number served in ICFs/MR had dropped to fewer than 850 (with 380 of those in large state-operated facilities). During this period, the state closed one of its large public facilities and considerably reduced the number of persons served in the remaining two. Some privately operated state facilities also closed down because of high vacancy rates.

tives include ensuring that individuals with disabilities have a good quality of life, are able to remain in their homes and contribute to their communities, and remain as independent as possible. The narrowness of the budget neutrality test obviously does not take into account these other important policy objectives and considerations.

In recognition of these other objectives, Federal policy does not dictate that states manage Medicaid long-term services (institutional and/or home and community services) in a way that achieves budget neutrality, except in very special circumstances (associated with the use of some special waiver authorities). When cost tests are employed (as in HCBS waiver programs), they are cost-effectiveness rather than budget neutrality tests. As a consequence, states are free to expand home and community services to whatever extent they desire in pursuit of their policy aims. In developmental disabilities services, for example, many states (e.g., New York, Maryland, Montana, Pennsylvania) have launched multi-year initiatives to reduce the number of individuals who have been wait-listed for home and community services. These states expect to finance the cost of these substantial expansions through their HCBS waiver programs for people with developmental disabilities.

State strategies to expand availability of home and community services include leveraging current state and local funds as matching dollars to secure additional Federal Medicaid dollars. It is not unusual, for example, for a state to combine existing and newly appropriated state dollars to underwrite the costs of home and community services expansion. This type of leveraging is permissible.

The main practical questions that arise when a state desires to expand availability of home and community services concern whether to use Medicaid state plan coverages or provide such services through an HCBS waiver program. Either option allows a state to impose various limitations in order to keep per recipient costs to pre-established targets. The main difference between the two is that an HCBS waiver program provides states with authority to limit the number of people who may receive benefits, whereas state plan services must be available to all individuals who meet whatever service eligibility criteria a state may have established—making utilization of a new state plan benefit (and its associated costs) hazardous to predict, and potentially costly to implement.

One reason states are employing HCBS waiver programs so extensively as a means to underwrite the expansion of home and community services is that the authority states have to limit the number of beneficiaries permits them to better predict spending and keep it within available state dollars. With respect to some policy objectives, especially in terms of making benefits broadly available, state plan coverage of home and community services is the best choice.

As has been said, the HCBS waiver program contains an explicit cost-effectiveness test. It must be emphasized, however, that concerns about both budget neutrality and cost-effectiveness permeate all state strategic planning with respect to long-term services and supports (whether in an institutional or a home and community context).

Managing Dollars: HCBS Waiver Programs

Federal law requires a state to ensure that its HCBS waiver program is cost effective.[8] Cost-effectiveness in this context is defined by compar-

ing the overall per capita costs to the Medicaid program of furnishing services to individuals in home and community settings with the overall per capita costs of serving individuals in an institutional setting. This test is spelled out in Medicaid regulations by the formula:

D + D' < G + G'

where:

D is the average per capita cost of HCB waiver services

D' is the average per capita cost of other Medicaid services furnished to HCBS waiver beneficiaries

G is the average per capita cost of furnishing institutional services

G' is the average per capita cost of other Medicaid services furnished to institutionalized persons.[9]

Institutional costs are defined as those incurred in the type of institutional setting to which the HCBS waiver program in question serves as an alternative. In an HCBS waiver program for people with developmental disabilities, for example, waiver costs would be compared to the costs of services furnished in an ICF/MR. In the case of an HCBS waiver program for medically fragile children, inpatient hospital costs might serve as the point of comparison.

The formula takes only Medicaid expenditures into account. It does not include public outlays on any non-Medicaid benefits that might be available to individuals in the community but not to institutionalized persons (e.g., public assistance, housing assistance, food stamps, and similar benefits).

The formula does include the costs of *other Medicaid services*, both for people who participate in an HCBS waiver program and for people served in institutional settings. The main reason why these other costs are included is to make sure that like is being compared with like. Usually, institutional reimbursements include health care services. When individuals are not institutionalized, the same services are obtained through the state's regular Medicaid program. Including other Medicaid costs also recognizes differences among states in the benefits available through the state Medicaid plan for people in the community. If a state provides extensive personal assistance services under its state plan, for example, not including the costs of such services would result in a distorted comparison between the costs of supporting a person in the home and community versus the costs of serving that individual in an institutional setting.

The present formula took effect in 1994. It replaced a much more complicated formula requiring that a state demonstrate not only that its HCBS waiver program would be cost effective but also that it would be budget neutral, upon implementation, with respect to the projected costs of furnishing only institutional services to the target population.[10]

The cost-effectiveness formula has no caseload factor. A state may limit the number of individuals who may receive benefits through an HCBS waiver program, however, by specifying a maximum number of beneficiaries for each year the program will be in operation. A state may change this maximum number at any time by notifying HCFA of the change.

HCFA evaluates HCBS waiver cost estimates in terms of unduplicated beneficiary counts.[11] Once the specified maximum is reached, a state is permitted to deny enrollment to individuals and place them on a waiting list until "slots" open up under the enrollment cap (due, as already noted, to ineligibility of current beneficiaries, beneficiaries moving to another state, institutionalization, people voluntarily leaving the program, or death). Furthermore, a state may tie its enrollment limit directly to appropriations made by the state legislature for HCB waiver services.

The HCFA standard HCBS waiver application format has an entire section, Appendix G, for state documentation of its estimates of the formula values. The values for institutional costs are already known or readily obtained. Factor D is estimated by projecting the extent to which individuals are expected to use the various services the program

will offer and how much the state expects to pay for such services. Often these estimates are based on the state's experience in operating home and community services with state or local funds. Factor D' is estimated in various ways, including looking at the costs of services for Medicaid beneficiaries in the same eligibility categories, or costs in HCBS waiver programs that serve similar populations. Splicing together the figures needed to complete Appendix G can be complicated in the case of a brand new program. Once a program is in operation, however, preparing the figures in conjunction with a renewal request is less complicated because there is cost experience on which to base estimates.

Always keep in mind that the estimates a state makes in submitting an application (or a renewal) are just that: estimates. Once a program goes into operation, use of particular types of services may be different than expected and it may be necessary to pay different rates than originally expected. In addition, each request (whether to start a brand new waiver program or renew an existing one) covers a multi-year period. The longer the period covered by the request, the more likely it is that estimates will be off the mark one way or another.

The state incurs no penalty if, upon actual implementation, the figures for the various factors in the formula turn out to be different than the estimates, *provided that the program is cost-effective according to the statutory test*. If a state estimates that the average cost of furnishing HCB waiver services will be $15,000 per individual, for example, but the cost turns out to be $16,000, the state will not be penalized so long as that test is met. Similarly, if a state estimates that 45 percent of all individuals will use personal assistance services but 53 percent actually do, Federal payments will not be reduced provided that the program still meets the overall cost-effectiveness test. In other words, the figures a state uses to come up with its estimate of Factor D in the formula are not considered "line item" budgets.[12]

Federal policy gives states various options with respect to managing per recipient costs. In particular, a state may impose a "hard" or absolute limit on the maximum dollar value of HCB waiver services that will be authorized for any beneficiary, or it may decide not to impose such a limit but, instead, to manage its program to meet a target average cost per beneficiary (sometimes called an aggregate cost limit). States may also take other measures designed to keep HCBS waiver outlays at targeted per recipient levels.

Hard cost limits

A hard limit sets a maximum dollar ceiling on the benefits an individual may receive. A state may set this limit equal to the costs of institutional services, but it may also set it higher or lower.[13] The main advantage to a state of a hard dollar limit in operating an HCBS waiver program is that the state can be more confident that it will achieve its targeted per recipient spending level, since there is a ceiling on maximum expenditures. The main problem in operating a program with a hard dollar limit is that individuals who need services and supports that require outlays in excess of the limit (even by a little) will be denied admission to the program and, hence, be able only to receive institutional services to meet their needs. This poses problems because it is often these individuals who are most at risk of institutionalization in the first place. Hard limits set well below the costs of institutional services lead to heightened demand for institutional services. Hard caps set nearer to institutional per recipient costs enable the needs of more individuals to be met in the home and community.

A state may soften the impact of a hard dollar cap by providing for approval of plans of care that exceed the dollar cap in specific situations (e.g., when an individual's condition requires provision of services in excess of normal levels). A state may also exempt certain services from being counted against the dollar cap. For example, the costs of furnishing home modifications may push an individual over the limit. But since home modifications are usually a one-time expenditure, a state may decide not to count these costs and instead look solely at the costs of services provided on a continuing basis.

More than one dollar cap is permitted when a state designs a waiver with multiple service options. A state may also place reasonable limits on the amount, scope, and duration of particular waiver services. A state may even operate multiple HCBS waiver programs for the same target

population—with different cost limitations for each program based on beneficiary characteristics, living situation, or other factors.

Managing to a targeted average

Managing its program to stay within a targeted per recipient cost average allows a state to approve service plans above institutional cost levels, or the targeted average, in the expectation that other plans of care will come in well below those levels—thus balancing the costs of the high service plans. HCBS waiver programs that operate in this fashion are usually able to accommodate a wider range of consumer needs than programs that operate under fixed cost caps.

Many HCBS waiver programs use the targeted average approach. Its main disadvantage is that costs are less predictable, especially for a new program, because they depend on whether enrollment patterns match the assumptions made. Costs are more predictable in longstanding programs, because information is available on actual utilization patterns among program participants.

One way states can achieve some predictability concerning HCBS waiver per recipient costs, while avoiding the disadvantages associated with the use of hard caps, is to impose special controls over use of services that might be particularly vulnerable to over-utilization. A state may impose unit limitations on services and/or require that use of certain services beyond established threshold levels be subject to additional professional or clinical review, for example. A particular advantage of this approach is that it enables the state to better ensure that the health and welfare needs of consumers are identified and met. The disadvantage of such controls is that, although costs are more predictable, the controls can cause problems in their own right, especially with respect to accommodating the needs of particular individuals and families. A variation on this approach is found in the Illinois supported living option benefit described in Chapter 8. This establishes an overall dollar limit that governs a service group but affords flexibility to the individual (or family) in deciding the exact mixture of services that will be used.

Correcting common misperceptions

There is no Federal requirement that dictates that the costs of supporting a particular individual via an HCBS waiver program may not exceed institutional costs. States may extend HCB waiver services to individuals who require extraordinary levels of support. Many states accommodate individuals who require costly supports in the community by virtue of their disability, while continuing to operate HCBS waiver programs that meet Federal cost-effectiveness tests. A state may find it necessary to impose hard cost caps for budgetary or other reasons, but the use of such caps is not dictated by Federal policy.

The HCBS waiver cost-effectiveness test does not discriminate against individuals who have complex conditions. Since HCBS waiver cost-effectiveness is measured against the cost of institutional services, a state may find it difficult to accommodate certain individuals, because the costs of serving them may be many times the institutional average and a state might not be able to accommodate such individuals even using aggregate cost caps. However, Federal law gives a state the latitude, when requesting a waiver, to compare the costs of serving individuals *with these intensive needs* in an institutional setting (rather than the average costs for all people receiving institutional services).[14] The average annual cost of nursing facility care in a state might be $36,000, for example. If the cost of serving a person who has had a brain injury in such a facility is $50,000, that higher figure may be used as the point of comparison.

There is no requirement that HCBS waiver programs be budget neutral with respect to Federal financial participation. Thus, Federal policy places no restrictions on the number of individuals a state may serve in its HCBS waiver program(s). Each state may establish whatever limit it chooses and may change its limits whenever it wishes.

Payment and Contracting Policies

An important aspect of system design for ensuring access to home and community services while promoting cost-effectiveness involves two intertwined topics: payment and contracting for serv-

ices. Payment policies should encourage the economical and efficient delivery of services, while also enabling a sufficient number of service providers to participate to ensure that the needs of clients are met. Further, contracting policies should foster efficient service delivery and may aid in expanding services availability.

Payments

It is frequently, but mistakenly, believed that Federal policy prescribes precise methods states must follow in purchasing Medicaid services. In fact, Federal policy requirements with respect to Medicaid payments are quite basic:

- States may generally not pay a provider any more than the provider charges other third parties for the same service.
- Except in certain circumstances (discussed below), a state's payment must be tied to actual delivery of a covered service to a particular beneficiary.
- State payment levels must be high enough to attract sufficient providers to meet the needs of beneficiaries.
- States are expected to be "prudent buyers," seeking out providers who will furnish services most economically while avoiding providers that have excessive costs.

Within these broad parameters, Federal policy gives states considerable latitude in the methods they use to make payments for home and community services. Thus, states may (and do) use any of a wide range of methods to determine the amount they will pay for home and community services. States may also use different methods for different services. Methods in current use include:[15]

- **Fee-for-Service Price Schedules.** The state establishes a uniform payment rate that applies to all providers of a service (e.g., compensating nursing services at the rate of $35 an hour regardless of the organization furnishing the services). Personal assistance attendant services are frequently reimbursed on this basis.
- **Cost-Based Payments.** The state bases payment rates on the allowable costs incurred by the specific provider, usually accompanied by upper limits on costs to encourage cost-effective service provision.
- **Negotiated Rates.** The state bases payment rates on the specific provider's actual or expected service costs.
- **Difficulty-of-Care Payments/Rates.** The state pays providers amounts that vary based on expected differences in the intensity of services and supports specific individuals require. Such methods seek to improve access to services for individuals with particularly complex needs and conditions.
- **Market-Based Payments.** The state purchases goods and services from generic sources (as in the case of engaging a contractor to install a wheelchair ramp or to connect an individual to an emergency response system offered by the local telephone company).

Medicaid payments for services are unit-, encounter-, or item-based. Units are usually expressed in terms of time (e.g., hours, days, months). Encounters may include contacts—an intervention (e.g., a mental health counseling session) that may differ in duration depending on the needs of the consumer, or various other means of establishing a documentable tie between the payment and an activity on behalf of the individual. Payment rates are tied directly to the billing unit or encounter established by the state. Medicaid accountability requirements mandate that claims for service payment be based on defined activities performed on behalf of eligible beneficiaries. Item-based payments are employed to secure home and vehicle modifications (e.g., installing a van-lift) as well as equipment and supplies (e.g., communication devices). Item-based payments are used for one-time purchases or buying supplies from approved sources. (For managed care purchasing alternatives see discussion later in this chapter.)

State payment methods for home and community services are not usually reviewed in depth by

HCFA during its review of state Medicaid plan amendments or an HCBS waiver application renewal. Such methods may be reviewed in the course of other Agency activities to ensure they comply with basic Federal requirements.

Correcting common misperceptions

There is no Federal requirement that payment may only be made for services furnished "face to face." It is not true that providers may only be paid for the time during which they are providing direct, "hands on" services in the presence of an individual. It can obviously take time for a worker to travel to the individual's home. In the case of certain services, advance preparation may be required. And case managers frequently conduct activities on behalf of individuals (e.g., arranging for an assessment or locating home and community services) that do not require the consumer to be present. When payment policies fail to take such additional time and effort required into account, providers understandably can be reluctant to offer services.

Medicaid payments may be made for all these types of activities, since they are recognized as integral to delivering the home and community service. States may compensate providers for the time they spend in addition to the face-to-face part of the activity in either of two ways: (a) directly, as long as the activity falls within the scope of the service itself (as defined by the state in its Medicaid State Plan or waiver program), and benefits a specific individual, or (b) indirectly, by adjusting reimbursement rates to take into account the additional activities necessary to furnish the service.

There is no Federal rule against making "wraparound" payments. A wraparound payment is a single payment to a provider for provision of multiple services to a particular individual (in lieu of making a distinct payment for each specific service). For example, a worker who comes to an individual's home may, during the course of the visit, provide personal care, perform homemaker services, help balance the person's checkbook, and provide skill training. In an instance like this, the worker should not have to submit four distinct claims for payment, or keep track of the exact amount of time spent on each activity (which is likely to vary from visit to visit). To avoid unnecessary paperwork and potential billing complications, a state may define an HCB waiver service that includes or "wraps around" the full range of activities that might be performed routinely on behalf of an individual. When states offer "residential services" (e.g., assisted living or group home services), for example, the associated service definitions encompass a wide range of activities on behalf of residents. A similar approach may be used with respect to services furnished to individuals in their own or the family home.

Apart from their value in avoiding unnecessary complications in billing and services reimbursement, wraparound payments can also help prevent over-utilization of services, promote more efficient service delivery, and improve flexibility. When a variety of services is wrapped into a single definition and paid on a single-fee basis, service providers have greater latitude to deploy resources when and as needed among the individuals they serve, taking into account changes in consumer needs or special situations that arise from day to day. Service-by-service payment arrangements, in contrast, frequently encourage providers to furnish excessive services in order to capture revenue.

Just how far states may go in collapsing the services they offer through an HCBS waiver program into single "wraparound" services has increasingly become an issue over the years. On occasion, HCFA has required states to break into separate categories services they were trying to wrap up in a consolidated service definition (sometimes called bundling). HCFA's concerns about bundling revolve mainly around whether an individual's choice of provider may be constricted if a single provider is receiving payment for several services.[16] Such concerns arise generally when a state is proposing to bundle an especially wide range of services, which might prevent some providers from participating because they are not able to furnish the full range. It should be emphasized that HCFA has no hard-and-fast rule against bundling or wraparound service definitions. When concerns do arise, they are worked out between HCFA and the state on a case-by-case basis.

There is no Federal rule that all services must be paid based on hourly rates. States establish hourly pay-

North Dakota's Per Diem Rates for Supported Living Services

North Dakota establishes individual per diem rates for people with developmental disabilities who receive supported living services through the state's HCBS waiver program. These rates are based on the hours of staff services and supports specific individuals are expected to require as spelled out in their service plans. North Dakota prices out the costs of these services for a month and converts the overall cost to a per diem rate. Because actual services furnished to any particular consumer may vary from the hours upon which the service plan was based for various reasons, North Dakota requires that providers reconcile the total amount of supports furnished to supported living participants against total payments for such services. If spending for direct supports is significantly less than payments for such supports, North Dakota recovers the difference. This guards against the potential that providers might profit by withholding services. It also enables provider agencies to shift direct staff resources among individuals as needed.

ment rates for many types of services. However, other billing/payment units may also be used. Residential services are typically reimbursed using daily or per diem payments, for example, because such services do not vary substantially from day to day. Some states make payments for adult day health and developmental disabilities day habilitation services on a daily basis. And in some cases, states make monthly payments for services (e.g., for residential services and case management services). With respect to respite care services, states often use a variety of payment units (e.g., hourly payments for short-term respite but daily payments for extended respite). The use of per diem or monthly payments can simplify provider billings and payments, as well as make it easier for provider agencies to predict their revenue.

Contracting

In order to promote access to home and community services, as well as to give individuals as many choices as possible among providers, it is important that states (a) design their service delivery systems to encourage as many providers as possible to participate and (b) seek to simplify their contracting mechanisms.

Federal Medicaid law and policy requires that states enter into provider agreements with agencies and individuals qualified to furnish Medicaid services; Medicaid payments may not be made without such provider agreements. Further, Medicaid law generally requires that payments be made directly to the service provider rather than to an intermediary organization.

These requirements have posed practical problems for states in implementing home and community service programs—some of which stem from state-specific factors, especially when state law directs that a local service authority (e.g., a designated regional or local mental health/developmental disabilities authority) manage the purchase of services on behalf of individuals who live in a particular service region or catchment area. These policies also can cause headaches in purchasing services from individual contractors (e.g., personal care attendants) with respect to both executing agreements and making timely payments.

In addition, states themselves have laws and regulatory requirements that can lead to additional complications in service contracting. State procurement rules might dictate, for example, that contracts be based on the results of a Request for Proposals (RFP) process. These and similar rules may make it especially difficult for a state to rapidly acquire needed goods and services on behalf of individuals.

Various avenues are available to states, consistent with the requirements of Federal Medicaid law and policy, that facilitate contracting for home and community services and expansion of the available provider pool.

The Organized Health Care Delivery Systems (OHCDS) alternative

An OHCDS is an organization that furnishes one or more Medicaid services itself and has agreements with other organizations or individuals that furnish additional services. Federal rules permit a state to contract with an OHCDS to purchase services on behalf of beneficiaries. These rules mandate that the affiliation of other organizations

OHCDS Arrangements: State Examples

Massachusetts. The state's Department of Mental Retardation (DMR) has been deemed an OHCDS for the state's HCBS waiver program for people with mental retardation. DMR furnishes case management services to program participants through its regional and area offices. Use of the OHCDS arrangement in Massachusetts has enabled DMR to follow congruent contracting policies for both Medicaid and non-Medicaid services. Providers bill and are paid by DMR, which in turn recoups Federal Medicaid payments.

Missouri. In its HCBS waiver program for people with mental retardation and other developmental disabilities, the state has designated its regional mental retardation and developmental disabilities offices as OHCDSs. These regional offices furnish service coordination to HCBS waiver participants as well as other individuals. Missouri selected the OHCDS mechanism in order to encourage and make it easier for individuals and families to secure services from "non-traditional" providers (e.g., neighbors, friends). The regional office takes care of ensuring that the selected individuals meet requirements and enters into agreements with them. These providers submit bills to and are paid by the regional offices.

with an OHCDS must be voluntary. They also prohibit a state from dictating that individuals must obtain services exclusively from an OHCDS. When a state purchases services from an OHCDS, the OHCDS itself enters into agreements with affiliate providers, including negotiating a reimbursement rate with the affiliate. These agreements must meet basic Medicaid requirements. Affiliate providers are paid by the OHCDS according to the provisions of their contracts. The OHCDS, acting as a Medicaid provider, submits these claims to and is paid by the state.

OHCDS arrangements are used in many states to simplify contracting and payments and are recognized in the Federal HCBS waiver guidelines contained in the State Medicaid Manual. New York, in particular, has used this type of arrangement for several years in purchasing state Medicaid plan personal care/personal assistance services. OHCDS contracting has several advantages:

- It can match up well with typical home and community service structures, which often feature contracting with "master providers" that seek out and contract with other agencies and individuals to furnish services to individuals.

- It helps avoid some of the problems and complications independent contractors face when they must seek payment through a state's Medicaid claims processing system. For example, if a family wishes to hire a neighbor to provide respite, standard Medicaid contracting and claims submission procedures might discourage such an arrangement. The OHCDS mechanism can enable agreements to be entered into more quickly, with the OHCDS addressing the complications of Medicaid claiming.

- The OHCDS mechanism can be particularly apt in aligning contracting and payment practices when a state or local program authority is involved in the purchase of services. It enables the state to use common contracting and payment processes for both Medicaid and non-Medicaid services, thereby avoiding duplication.

- A provider is not restricted to furnishing services through an OHCDS. The provider may elect to bill the Medicaid agency directly, and be paid directly as well.

Other ways to improve service availability

Other alternatives are available to states as well. For example, Medicaid law and regulation permit providers to assign Medicaid payments to governmental entities (again on a voluntary basis).[17] This provision enables voluntary (re)assignment of Medicaid payments by a provider to a governmental entity (e.g., a county human services authority or a state program agency). Instead of the Medicaid payment being made directly to the provider, it is made to the governmental entity. This arrangement enables the governmental entity to make payments for services directly to providers, and to recoup Medicaid funds once the

service billing has been processed through a state's claims payment system. This arrangement may be used, for example, to enable a county human services agency to pay a personal assistant the consumer has selected, prepare and submit the claim for services provided, and receive the Medicaid payment to recoup the payment to the personal assistant. This permits more timely payments to be made to the personal assistant. In some states and localities, such an arrangement has greatly facilitated consumer-direction and self-determination in the provision of services, both through HCBS waiver programs and under the Medicaid state plan.

Medicaid law also provides for the assignment of claims to billing agents who, in turn, take care of the paperwork in obtaining Medicaid reimbursement. This alternative facilitates the use of financial intermediaries in consumer-directed models.

A key objective for states is to offer individuals and families a wide range of choices in the providers (agency or independent contractor) from which they obtain the home and community services they are authorized to receive. The alternative contracting mechanisms just described can aid in achieving this objective. A state may take other steps as well, including:

- Making sure the provider qualifications required of home and community services do not unnecessarily exclude potential suppliers—including independent contractors or other nontraditional sources of goods and services. For example, private housecleaning services can be an appropriate source of homemaker or chore services, rather than requiring such services to be furnished by human service agencies.

- Avoiding Request for Proposals (RFP) processes that have the effect of narrowing the number of agencies from which services can be purchased. Winner-take-all processes, for example, can discourage entry of new providers into a state's program and may violate Medicaid freedom of choice requirements. Request for Qualifications (RFQ) processes can frequently serve as appropriate substitutes. They enable a state to qualify multiple agencies to furnish services while also satisfying legitimate concerns about organizational capabilities and qualifications. The RFQ process was used successfully by Georgia, in identifying several qualified provider organizations to furnish services to individuals through a targeted HCBS waiver program. This program was implemented to facilitate community placement of individuals with mental retardation out of various state facilities.

- Cross-certification of providers among home and community services. Rather than having distinct provider requirements for each program serving a particular target population (except as necessary and appropriate), states can adopt common standards for similar services, and accept the certification of a provider for one HCBS waiver program as demonstrating that the provider meets the qualifications of other programs where similar services are furnished.

Innovative Mechanisms for Organizing Home and Community Services under Medicaid

As in the general health arena, there is interest in new mechanisms for organizing home and community services. These mechanisms generally build upon managed care arrangements to organize home and community service systems in ways that are potentially beneficial to both purchasers and consumers. It is important to note that, while application of managed care arrangements in the market for acute care services has become widely accepted, implementation of such arrangements in the long-term services market is still in its experimental stages and, as a consequence, is uncommon. The market for long-term services is very different from the market for acute care services, and the outcomes achieved through managed care technologies in acute care delivery may not be replicable in the long-term services field. Recently, however, some states have started implementing such arrangements (e.g., Minnesota, Texas, Florida.) They are doing so in pursuit of several goals:

- To tie payments for services to people rather than to specific services (i.e., through capitation)
- To purchase bundled services rather than individually distinct services
- To give providers and consumers of services flexibility to allocate resources in response to individualized needs
- To give providers and consumers flexibility to use Medicaid resources for new types of supportive services that might not otherwise be covered under the state Medicaid plan
- To promote more cost-efficient use of resources by placing providers/health plans at risk for the cost of services provided to consumers
- To reward with increased market share those providers/health plans that provide higher quality services
- To help promote quality by allowing consumers to choose among multiple providers/health plans that are competing with one another for market share.

Many of these objectives can also be achieved through a fee-for-service system. But proponents argue that managed care mechanisms make attainment of them easier. The next section discusses some of the specific managed care vehicles potentially available to states for organizing home and community services under Medicaid.

Prepaid Health Plans

Medicaid statute and regulation, as recently revised under the Balanced Budget Act (BBA) of 1997, recognizes two broad types of managed care entities with which states can enter into risk contracts. The first consists of comprehensive risk plans, or Managed Care Organizations (MCOs). These are entities that accept risk for a comprehensive package of Medicaid benefits (although one or more services covered under the regular state plan may be "carved out" of the comprehensive risk contract).[18] The other type of entity is a Prepaid Health Plan (PHP), which, by default, accepts risk for a less comprehensive package of Medicaid benefits. A managed care entity that accepts risk only for a benefit package that includes all services provided under an HCBS waiver program, for example, would be considered a PHP.

The differences between an MCO and a PHP are fairly technical and will not be discussed in detail here.[19] Both MCOs and PHPs often enact a utilization or care management function, whereby a primary care provider or managing entity authorizes medically necessary services before care is delivered and has a panel of providers to whom beneficiaries go to for care.

A small number of states have used the PHP authority as a purchasing strategy for home and community services. Florida has contracted with United Health Care under the PHP authority since the mid-1980s, for example, to manage its entire Medicaid home and community service population in three counties: Dade, Broward, and Palm Beach.

Wisconsin uses the PHP authority for purchasing services under its Partnership Program. Wisconsin's PHP contracts bundle payments, not only for services covered under the state's HCBS waiver program but also other selected Medicaid health and long-term services benefits (e.g., personal care services). The PHP contracting mechanism gives the managing organization considerable flexibility to organize, provide, or obtain services on behalf of enrollees. This mechanism also enables the PHP to apply any savings it might achieve in providing existing services to providing enrollees with additional benefits and/or enhancing service delivery. Consumer choice is maintained, because individuals may opt to enroll with the PHP or continue to receive services through the state's fee-for-service long-term services system.

1915(b) Waivers

The Balanced Budget Act (BBA) of 1997 allows states the option to submit a State Plan Amendment to mandate enrollment of certain groups of Medicaid eligibles into MCOs or PHPs.[20] Prior to the BBA, states had to obtain authority under a 1915(b) waiver or a Section 1115 demonstration to mandate enrollment of any group in managed

care organizations.[21]

Among the groups exempted from this option, however, are those individuals who are eligible for both Medicare and Medicaid ("dual eligibles") or other persons receiving long-term care services. Thus, some states have used 1915(b) freedom of choice waivers to implement managed care purchasing strategies for their Medicaid long-term care populations. Section 1902(a)(23) of the Social Security Act specifies that Medicaid beneficiaries be allowed to gain access to care from any Medicaid participating provider. However, since PHP and MCO networks consist of a finite group of providers, and often the beneficiary must obtain authorization for care, 1915(b) authority can be used to waive Section 1902(a)(23).

1915(b) waivers allow states to waive Medicaid's freedom of choice provisions to require particular groups of beneficiaries to receive their Medicaid-covered benefits through a managed care plan.[22] Many states use 1915(b) waivers to provide mental health and substance abuse services to their general welfare-related Medicaid beneficiaries.[23] Under these managed care models, such Medicaid beneficiaries may receive their physical health services through either the fee-for-service system or a managed care entity. But they must obtain their acute mental health and/or substance abuse services through a separate managed entity specializing in the delivery and management of these services.[24]

A smaller number of states have used 1915(b) waivers to provide long-term mental health services to persons with severe and persistent mental illness. These programs may be either part of a broader managed care initiative or an initiative targeted specifically to the needs of persons with severe and persistent mental illness. As part of a relatively broad mental health/substance abuse managed care program, for example, Colorado contracts with a variety of managed care entities (but primarily Community Mental Health Centers operating as PHPs) to provide a broad range of inpatient and outpatient services, including 24-hour residential care, to Medicaid beneficiaries with long-term mental health needs. By purchasing services for Medicaid beneficiaries with severe and persistent mental illness through such managed care models, Colorado is creating incentives for providers to meet the needs of the population more cost-effectively, while adhering to state and Federal quality standards. These models also allow mental health providers some flexibility in providing services that are not covered under the regular state plan.

1915(b) waivers cannot be used alone as a vehicle for providing home and community services to elderly and nonelderly Medicaid beneficiaries through managed care models. However, as discussed further below, a few states are now using what are called combination 1915(b)(c) waivers to finance and deliver such services through managed care strategies.

Combination 1915(b)(c) Waivers

A combined 1915(b)(c) waiver program is a relatively new vehicle for organizing the financing and delivery of home and community services under managed care models. The 1915(c) waiver authority allows a state to cover home and community services that are not eligible for Federal matching funds under the regular state plan. The 1915(b) waiver authority allows a state to deliver these services to persons in need of long-term care services through a managed care contracting approach.

The 1915(b)(c) waiver combination is somewhat cumbersome because, even though the waivers are intended to work in combination with one another, each waiver program must be submitted and evaluated separately under existing regulatory requirements. For example, each waiver must meet its own cost neutrality or cost-effectiveness test independently, without taking into account the cost impacts of the other. Also, each waiver has its own duration and its own reporting requirements, which states must comply with. Nonetheless, 1915(b)(c) waiver combinations are often perceived as preferable to Section 1115 waivers as vehicles for implementing innovative HCBS financing and delivery programs. This preference is likely because the 1915(b)(c) review process is quicker and more circumscribed. Section 1115 demonstration negotiations between states and HCFA are not as definitive and some-

Texas's Use of Combined 1915(b)(c) Waiver Authority

The Texas STAR+PLUS program operates under a combined 1915(b)(c) waiver. STAR+PLUS is a pilot program using a managed care delivery system to integrate acute health services with long-term care services for individuals with disabilities (including seniors). By integrating care in this manner, the state aims to: (a) provide the appropriate amount and types of services to help people stay as independent as possible; (b) serve people in the least constrained setting consistent with their safety; (c) improve care access, quality, and outcomes; (d) increase accountability for care; and (e) control costs. The project is expected to serve approximately 60,000 SSI and SSI-related Medicaid beneficiaries who are elderly or have disabilities.[25] Participants must choose from one of three health maintenance organizations (HMOs), two of which also offer Medicare managed care.

STAR+PLUS will benefit Medicaid beneficiaries by providing a continuum of care with a wider range of options than were formerly available and increased flexibility to meet individual needs. The program is expected to increase the number and types of providers available to Medicaid clients and move individuals into the health care mainstream. HMOs are required to assess all STAR+PLUS enrollees to determine needs and to develop appropriate care plans. By placing HMOs at full risk for nursing facility and expanded home and community services, STAR+PLUS presents HMOs with an incentive to provide innovative, cost-effective care from the outset, in order to prevent or delay the need for more costly institutionalization.

Long-term services and supports provided by the HMOs include day activity and health services, personal assistance, and nursing facility care. Additional services provided to HCBS waiver participants are adaptive aids, adult foster home services, assisted living, emergency response services, medical supplies, minor home modifications, nursing services, respite care, and therapies (occupational, physical, and speech/language). HMOs may also provide additional "value-added" services to clients, such as home and community services to those living in the community who are not currently enrolled in an HCBS waiver program.

Care coordination is an integral STAR+PLUS service. All HMOs must assign clients a care coordinator, who plays a central role in integrating care. This person is responsible for coordinating the client's acute and long-term care services, even for dual-eligible clients who receive Medicare from a provider who is not affiliated with the STAR+PLUS HMO's Medicare plan.

times have more specified terms and conditions of approval that require more intense reporting.

In 1998, Michigan implemented a Section 1915(b)(c) waiver program for people with developmental disabilities. Through this program, Michigan has been able to establish a uniform package of benefits for people with developmental disabilities. Previously, Medicaid state plan long-term services (including most ICF/MR, personal care, and clinical services) did not align with the benefits available through the state's HCBS waiver program for people with developmental disabilities. The Section 1915(b)(c) program permitted the state to align both state plan and HCBS waiver benefits to make a single package available to eligible persons with developmental disabilities and, thereby, remove artificial distinctions between state plan and waiver benefits.

Michigan decided to use the PHP contracting mechanism to contract for services with its existing network of county-based Community Mental Health Service Programs (CMHSPs). Instead of making service-by-service, consumer-by-consumer payments for long-term developmental disability services, the CMHSPs are now receiving capitated payments in advance and must manage the dollars they receive (within a "risk corridor") to meet the needs of individuals within their catchment areas. Contracting for and paying service providers is the responsibility of the CMHSP.

As in the case of Wisconsin's PHP system, the PHP contracting mechanism enables Michigan's CMHSPs, when they realize cost savings, to either purchase alternative services on behalf of enrollees or provide additional services beyond those mandated in their contract. Michigan's PHP contracts place affirmative requirements on PHPs to ensure that individuals are able to choose among service providers. In addition, state law requires that consumer service plans be developed using person-centered planning principles.

Section 1115 Waivers

Section 1115 demonstrations are the broadest Medicaid waiver authority available to states that wish to test innovative approaches to financing and delivering medical and supportive services to Medicaid beneficiaries. The general purpose of the Section 1115 demonstration authority is to allow states to experiment under the Medicaid program with new policies that could potentially further the overall objectives of the Medicaid program. Any policy experiment proposed under a Section 1115 demonstration must be a program model that has not been tested previously. It must also be an experiment that cannot potentially be conducted within the boundaries of more limited waiver authorities such as 1915(b) or 1915(c) waivers. And it must be amenable to rigorous evaluation, so that the results of the policy experiment can be used for further Medicaid policy development.

Fewer Section 1115 demonstration programs are currently being tested than in the recent past, particularly in the long-term care arena, for two reasons. First, both HCFA and states are electing to use more circumscribed waiver authorities whenever the program models to be tested fit within the boundaries of these more limited waivers. Second, since Section 1115 demonstrations are not subject to prescribed processing times, negotiations between states and HCFA, particularly on issues related to the requirement for rigorous evaluation methodologies, can take years to complete. States are increasingly reluctant to undergo such a long negotiating period in order to conduct a policy experiment.

In the area of home and community service development, the Section 1115 waiver program of greatest importance is the Arizona Long Term Care System (ALTCS). Originally implemented in 1989, ALTCS is a statewide managed care program for all Medicaid beneficiaries in need of long-term care services. All elderly and nonelderly persons with disabilities who qualify for Medicaid-covered long-term care benefits—whether nursing home care or home and community services—receive all their Medicaid-covered benefits, including acute care services, from a managed care plan (called a program contractor in ALTCS).

There is one program contractor per county. Thus, Medicaid beneficiaries do not have a choice of multiple plans, although ALTCS is now moving to a program model in which multiple program contractors will compete for business in Arizona's largest county—Maricopa (which includes Phoenix). ALTCS program contractors receive a monthly capitation payment for each long-term care beneficiary enrolled in their plan, and operate under financial incentives to meet the long-term care needs of their enrollees through the most cost-effective care plan. Under the ALTCS program model, Arizona has significantly expanded its use of home and community alternatives to nursing home services for its Medicaid clients. Independent evaluations of the program have generally concluded that the ALTCS program model is more efficient than Medicaid long-term care systems that rely on fee-for-service models.[26]

Program of All-Inclusive Care for the Elderly (PACE)

Since the early 1980s, states have been operating PACE demonstration sites as Section 1115 demonstrations. As of June 2000, PACE sites had been approved in 12 states. The PACE demonstration programs are modeled after the integrated system of acute and long-term care services developed by On Lok Senior Health Services in San Francisco, California. The Balanced Budget Act of 1997 (BBA) established the PACE model of care as a permanent provider entity within the Medicare/Medicaid program and enables states to provide PACE services to Medicaid beneficiaries as a state option rather than a demonstration.

PACE is a capitated benefit that features a comprehensive service delivery system and integrated Medicare and Medicaid financing. Participants in PACE must be at least 55 years old, live in the PACE service area, and be certified by the appropriate state agency as eligible for a nursing home level of care. The PACE program becomes the sole source of services for its Medicare and Medicaid enrollees. The program is voluntary; beneficiaries may disenroll at any time.

An interdisciplinary team of professional and paraprofessional staff assesses participants' needs, develops care plans, and delivers all services (including acute care services and, when necessary, nursing facility services), in an integrated manner. PACE programs provide social and medical services primarily in an adult day health center, supplemented by in-home and referral services in accordance with the participant's needs. The PACE service package must include all Medicare- and Medicaid-covered services and any other services determined necessary by the multidisciplinary team for the care of the PACE participant.

PACE providers receive monthly Medicare and Medicaid capitation payments for each eligible enrollee. Medicare-eligible participants not eligible for Medicaid pay monthly premiums equal to the Medicaid capitation amount. But no deductibles, coinsurance, or other type of Medicare or Medicaid cost-sharing applies. PACE providers assume full financial risk for participants' care without limits on amount, duration, or scope of services.

Endnotes

1. The primary contributors to this chapter are Gary Smith and Janet O'Keeffe.

2. States establish and administer their Medicaid programs in accordance with Federal statutory and regulatory provisions and submit their administrative expenditures to HCFA for approval.

3. HCFA letter to state Medicaid directors, August 31, 2000. Available at the following website: www.hcfa.gov/medicaid/smd83100.htm.

4. HCFA's policies with respect to the use of these alternatives are contained mainly in Section 4302 of the State Medicaid Manual. See also: Cooper, R.E., and Smith, G. (1998). *Medicaid and case management for people with developmental disabilities: Options, practice and issues.* Alexandria, VA: National Association of State Directors of Developmental Disabilities Services.

5. Smith, G. (1999). *Closing the gap: Addressing the needs of people with developmental disabilities waiting for supports*. Alexandria, VA: National Association of State Directors of Developmental Disabilities Services, Inc.; Smith, G. (1999). *A supplement to Closing the gap: Addressing the needs of people with developmental disabilities waiting for supports*. Alexandria, VA: National Association of State Directors of Developmental Disabilities Services, Inc.

6. Per capita costs, in turn, are affected by the extent to which individuals use the particular home and community services a state offers and the price paid for the services. Issues with respect to pricing are addressed separately in a later section of this chapter.

7. It is also difficult to achieve budget neutrality due to political pressures and practical concerns at the state level. For example, it would be difficult to close down a nursing home even if 90 percent of the residents were moved into HCBS waiver programs.

8. Section 1915(c)(2)(D) of the Social Security Act.

9. 42 CFR 441.303(f)(1).

10. Sometimes called the cold bed rule.

11. 42 CFR 441.303(f).

12. At the conclusion of each year, the state is required to prepare and submit to HCFA a special report (Form HCFA 372) that provides data concerning the actual cost-effectiveness of the state's program. When these data suggest that the state's estimates do not correspond to actual program experience, the state may be encouraged to amend its waiver to ensure that estimates are reasonable, as required by law.

13. The HCBS waiver application form provides directly for a state establishing a "hard cap" on the costs of institutional services. A state may select or reject this limit as it pleases. However, if rejected, a state must specify substitute limits of its choosing for the options contained in the application.

14. Section 1915(c)(7)(A) of the Social Security Act.

15. A discussion of the technical pros and cons associated with each of these methods is beyond the scope of this Primer.

16. HCFA is concerned that institutional models of care not be replicated in the community. In an institution, the facility assumes responsibility for identifying and meeting a resident's needs. In HCBS models, this responsibility is separate from the community-based milieu in which the individual lives. This separation is fundamental to the concept of community integration and the provision of services in the most integrated setting appropriate to a person's needs.

HCBS waiver programs are not intended to foster the re-creation of multiple (presumably smaller) "institutions" dispersed throughout the community. Rather, the program supports freedom of choice of providers for service and support needs. This purpose underlies

HCFA's expressed concern that "bundled" services may infringe on a beneficiary's freedom of choice by (a) limiting providers to those who can furnish the full range of bundled services, and (b) removing individuals' ability to participate fully in community life by eliminating their choice of service modality and provider.

17. Section 1902(a)(32)(B) of the Social Security Act and regulation 42 CFR 447.10(c).

18. Carving out a particular service means that it will not be included in the capitation rate but furnished by another provider.

19. For a more detailed discussion see Hamilton, T. (1995). *Using pre-paid health plan authority to provide integrated acute and long term care services under Medicaid.* Wisconsin Department of Health and Social Services.

20. Even after the State Plan Amendment became an option under the BBA, there are still certain groups that states cannot mandate enrollment for (e.g., children with disabilities).

21. Both 1915(b) and 1115(a) contain the authority to waive Section 1902(a)(23), the right of Medicaid beneficiaries to have freedom of provider choice.

22. Freedom of choice here means that under Medicaid's traditional fee-for-service system, Medicaid beneficiaries are free to receive Medicaid-covered services from any Medicaid-certified provider of their choosing. Under a 1915(b) managed care waiver, Medicaid beneficiaries must receive their Medicaid-covered services (i.e., those services covered under the managed care contract) from those providers included in their managed care plan's network.

23. These are recipients of benefits under Temporary Assistance for Needy Families (TANF), the successor of Aid to Families with Dependent Children (AFDC).

24. For a description of state Medicaid managed care programs for mental health and substance abuse services, see *State profiles, 1999, on public sector managed-behavioral health care* (May 2000). Washington, DC: Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

25. SSI-related beneficiaries are those who meet the SSI disability criteria but are not receiving SSI benefits because they have too much income or for other reasons.

26. McCall, N., Wrightson, C., Korb J., Crane, M., Weissert, W., and Wilkin, J. (1996). *Evaluation of Arizona's health care cost containment system demonstration*. Prepared for the Health Care Financing Administration by Laguna Research Associates.

Annotated Bibliography

Coleman, B. (October 1998). *New directions for state long-term care systems [2nd Edition]*. Pub. #9809, Washington, DC: AARP, Public Policy Institute. (30 pages)

This issue paper describes the strategies used by states to increase and improve the organization, financing, and delivery of publicly funded long-term care services, particularly home and community based care services. *To obtain a free copy of this document, contact AARP's Public Policy Institute at (202) 434-3860 or search their website at www.research.aarp.org. Publication ID: 9809.*

Wiener, J., and Stevenson, D. (August 1998). *Long-term care for the elderly: Profiles of thirteen states.* Washington, DC: The Urban Institute. (61 pages)

Part of the Urban Institute's "Assessing the New Federalism" project, this paper analyzes long-term care services for older adults in thirteen states (AL, CA, CO, FL, MA, MI, MN, MS, NJ, NY, TX, WA, and WI). It summarizes initiatives by these states to control the rate of increase in Medicaid long-term care expenditures for the elderly. *This article may be obtained free of charge from the Urban Institute website at www.urban.org/authors/wiener or by contacting the Urban Institute at (202) 833-7200.*

Weiner, J., and Stevenson, D. (May/June 1998). *State policy on long-term care for the elderly: States approach their long-term care policies differently, but all agree that curbing spending is top priority*. *Health Affairs* 17 (3): 81-100. (20 pages)

This article discusses state initiatives to provide long-term care. It looks at state objectives, difficulties in cutting costs, and Medicare maximization policies. The